



**By Fax:**  
 Fax to 312.541.4472  
 and transmit a copy of  
 your purchase order.

**By Phone:**  
 800.267.2727  
 Monday–Friday (8am–6pm ET)  
 (Outside the US 312.541.4848)  
 Please have credit card  
 information ready.

**By Mail:**  
 ASCP  
 3462 Eagle Way  
 Chicago, IL 60678-1034  
 Include check payable to ASCP  
 or purchase order.

**YES!** Please renew my CheckPath subscription for 2020 as indicated.

Product Name	Price	Quantity	# of Participants	Quantity x Price
<input type="checkbox"/> Anatomic Pathology (CPAN20-GLASS)	\$899	_____	_____	\$ _____
<input type="checkbox"/> Clinical Pathology (CPCL20)	\$899	_____	_____	\$ _____
<input type="checkbox"/> Hematopathology (CPHM20-GLASS)	\$899	_____	_____	\$ _____
<input type="checkbox"/> Anatomic Pathology Virtual (CPAN20-VIRTUAL)	\$599	_____	_____	\$ _____
<input type="checkbox"/> Clinical Pathology Virtual (CPCL20-VIRTUAL)	\$599	_____	_____	\$ _____
<input type="checkbox"/> Hematopathology Virtual (CPHM20-VIRTUAL)	\$599	_____	_____	\$ _____
<input type="checkbox"/> Virtual Materials with Glass Slides	\$699	_____	_____	\$ _____
<input type="checkbox"/> CPAN20-VGLASS				
<input type="checkbox"/> CPHM20-VGLASS				
Total # of participants _____ x \$95.29 per program =				\$ _____
<b>Grand Total</b>				\$

Participant Name

<b>SHIP CUSTOMER #</b>	<b>BILL CUSTOMER #</b>
------------------------	------------------------

**Please verify your shipping and billing information.** Indicate any changes.

<b>SHIPPING ADDRESS:</b>	<b>BILLING ADDRESS:</b>	Purchase Order Number (please attach a copy of the purchase order) _____
		Contact Person _____
		<b>E-mail (required)</b> _____
		Phone _____ Fax _____
		<input type="checkbox"/> I want to pay by credit card. Please call me at _____
		Date/Time _____